		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017996

Facility Name: Southgate Health Care Center

Address: 900 East 9th St. (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2683 **Fax #** (618) 524-3048

IDPA ID Number: 370993462001

Date of Initial License for Current Owners: 01/01/1964

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,983	313	4,413	9,709	8
9	SNF/PED					9
10	ICF	28,242	7,548	409	36,199	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,225	7,861	4,822	45,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.84%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/25/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 4,004

Medicare Intermediary AdminaStar Federal (Louisville, KY)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	144,729	12,897	7,898	165,524		165,524		165,524			1
2	Food Purchase		184,863		184,863		184,863	(1,199)	183,664			2
3	Housekeeping	107,173	19,607		126,780		126,780		126,780			3
4	Laundry	67,106	9,464		76,570		76,570		76,570			4
5	Heat and Other Utilities			66,277	66,277		66,277		66,277			5
6	Maintenance	71,055	19,157	31,747	121,959		121,959		121,959			6
7	Other (specify):*											7
8	**TOTAL General Services**	390,063	245,988	105,922	741,973		741,973	(1,199)	740,774			8
	B. Health Care and Programs											
9	Medical Director			3,900	3,900		3,900		3,900			9
10	Nursing and Medical Records	943,051	141,399	4,356	1,088,806		1,088,806		1,088,806			10
10a	Therapy			228,872	228,872		228,872		228,872			10a
11	Activities	67,780	1,869		69,649		69,649		69,649			11
12	Social Services	45,508			45,508		45,508		45,508			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,056,339	143,268	237,128	1,436,735		1,436,735		1,436,735			16
	C. General Administration											
17	Administrative	399,812			399,812		399,812		399,812			17
18	Directors Fees			8,000	8,000		8,000		8,000			18
19	Professional Services			31,657	31,657		31,657	(4,763)	26,894			19
20	Dues, Fees, Subscriptions & Promotions			23,585	23,585		23,585	(10,506)	13,079			20
21	Clerical & General Office Expenses	105,168	19,357	49,304	173,829		173,829		173,829			21
22	Employee Benefits & Payroll Taxes			310,094	310,094		310,094		310,094			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,054	11,054		11,054	(4,819)	6,235			24
25	Other Admin. Staff Transportation		908	13,221	14,129		14,129		14,129			25
26	Insurance-Prop.Liab.Malpractice			83,966	83,966		83,966		83,966			26
27	Other (specify):*											27
28	**TOTAL General Administration**	504,980	20,265	530,881	1,056,126		1,056,126	(20,088)	1,036,038			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,951,382	409,521	873,931	3,234,834		3,234,834	(21,287)	3,213,547			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Southgate Health Care Center #0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			135,775	135,775		135,775	13,330	149,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,271	24,271		24,271	(9,533)	14,738			32
33	Real Estate Taxes			17,306	17,306		17,306		17,306			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,089	16,089		16,089		16,089			35
36	Other (specify):*											36
37	**TOTAL Ownership**			193,441	193,441		193,441	3,797	197,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	152,412	117,258	10,918	280,588		280,588		280,588			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):* Nonallowable Costs			30,641	30,641		30,641	(30,641)				43
44	**TOTAL Special Cost Centers**	152,412	117,258	118,209	387,879		387,879	(30,641)	357,238			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,103,794	526,779	1,185,581	3,816,154		3,816,154	(48,131)	3,768,023			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,330	30		9
10	Interest and Other Investment Income	(9,533)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(257)	43		19
20	Contributions	(1,372)	43		20
21	Owner or Key-Man Insurance	(39,687)	43		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	40,821	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,438)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,973)	20		28
29	Other-Attach Schedule See Schedule 5A	(31,022)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (48,131)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (48,131)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center
Facility #: 0017996
01/01/2002 - 12/31/2002

Page 5 - Non-allowable Expenses

Description	Amount	Ref
Lobbying expense	(2,941)	20
PAC contribution	(212)	20
PAC contribution	(736)	43
Medicare & VA lab fees	(2,319)	43
Out-of-state travel & seminar	(4,819)	24
Non-allowable travel & entertainment	(1,615)	43
Sales tax	(17)	43
Car & gas expense	(3,521)	43
Marketing expense	(8,500)	43
Offset vending income	(1,199)	2
Legal (collection) fees	(4,763)	19
Chamber of Commerce & Kiwanis dues	(380)	20
	(31,022)	

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center **#** 0017996 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,973)	0	0	0	0	0	0	0	0	0	0	(6,973)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,973)	0	0	0	0	0	0	0	0	0	0	(6,973)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,973)	0	0	0	0	0	0	0	0	0	0	(6,973)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	13,330	0	0	0	0	0	0	0	0	0	0	13,330	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,533)	0	0	0	0	0	0	0	0	0	0	(9,533)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,797	0	0	0	0	0	0	0	0	0	0	3,797	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,933)	0	0	0	0	0	0	0	0	0	0	(13,933)	43
44	**TOTAL Special Cost Centers**	(13,933)	0	0	0	0	0	0	0	0	0	0	(13,933)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,109)	0	0	0	0	0	0	0	0	0	0	(17,109)	45

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane Ann Parker	86.00					
Sam Thompson	4.67					
Jeff Thompson	4.67	N/A		N/A		
Shelly MacCauley	4.66					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V				N/A				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Thompson	Operations	Administrative	4.67	None	40+	66.67	Salary	$ 335,455	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	4.67	None	40+	100.00	Salary	30,866	6(1)	2
3											3
4	Sam Thompson	Director	Administrative	4.67	None	40+	66.67	Director Fees	2,000	18(3)	4
5	Jeff Thompson	Director	Administrative	4.67	None	40+	100.00	Director Fees	2,000	18(3)	5
6	Jane Ann Parker	Director	Administrative	86.00	None	<2	10.00	Director Fees	2,000	18(3)	6
7	Shelly MacCauley	Director	Administrative	4.66	None	<1	0.00	Director Fees	2,000	18(3)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 374,321		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6					N/A					6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Community National Bank		X	Mortgage	$12,689.00	11/01/97	$ 1,300,000	$	12/14/02	0.0825	$ 22,601	1
2	Banterra Bank		X	Vehicle purchase	$360.00	08/24/00	11,154	7,326	08/23/03	0.1000	507	2
3	Banterra Bank		X	Vehicle purchase	$948.00	08/24/00	29,810	2,771	08/23/03	0.0900	1,163	3
4	GMAC		X	Vehicle purchase	$1,130.00	10/31/02	40,686	38,426	10/31/05	zero %		4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$15,127.00		$ 1,381,650	$ 48,523			$ 24,271	9
	B. Non-Facility Related*											
10												10
11								Less: Interest income offset			(9,533)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,533)	14
15	TOTALS (line 9+line14)						$ 1,381,650	$ 48,523			$ 14,738	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 16,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 17,006	2
3. Under or (over) accrual (line 2 minus line 1).		$ 206	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 17,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 17,306	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	15,376	8
	1998	15,241	9
	1999	15,768	10
	2000	16,739	11
	2001	17,006	12

Current tax bill rounded up to nearest $100 = $17,100

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT Janie Owsley

TELEPHONE (618) 524-2863 FAX #: (618) 524-3048

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-450-001	BK 150	$ 16,489.26	$ 16,489.26
2.		All blk 150 ex triangular portion	$	$
3.		parcel n pt of:	$	$
4.		Addition to Metropolis	$	$
5.			$	$
6.	08-01-451-01	BK 151	$ 517.10	$ 517.10
7.		Addition to Metropolis	$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 17,006.36	$ 17,006.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,622 B. General Construction Type: Exterior Brick Frame Concrete block Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	185,500	1972	$ 5,000	1
2	Resident care	193,500	2002	95,000	2
3	TOTALS	379,000		$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1972	1972	$ 207,276	$ 3,108	30	$ 6,909	$ 3,801	$ 189,998	4
5	37			1976	289,344	10,716	30	9,645	(1,071)	255,593	5
6	10			1989	583,147	18,513	30	19,438	925	262,113	6
7	5			1993	598,429	15,344	30	19,948	4,604	189,506	7
8				1994	13,658	350	30	455	105	4,075	8
	Improvement Type**										
9	Land improvements			1975	7,341		10-30			7,341	9
10	Land improvements			1976	2,886		20			2,886	10
11	Building improvements			1977	1,098		28			1,098	11
12	Land and building improvements			1980	1,014		20			1,014	12
13	Building improvements			1981	57,891		15			57,891	13
14	Land & building improvements			1982	17,279		5-20			17,279	14
15	Building improvements			1983	675		10			675	15
16	Bushes & gravel			1984	888		10			888	16
17	Patio, Med room & improvements			1984	13,078	685	15		(685)	13,078	17
18	Building addition			1984	100,925	4,490	20	5,046	556	95,874	18
19	Gravel road & painting			1985	7,365		3-20			7,365	19
20	Improvements			1985	17,960		15			17,960	20
21	Fire alarm & barn			1985	3,568		20	179	179	3,132	21
22	Improvements			1986	13,163		15			13,163	22
23	Kitchen remodeling			1988	32,477	1,031	30	1,084	53	15,706	23
24	Overhead door/kitchen			1989	852		15	57	57	769	24
25	Flooring			1990	729		10			729	25
26	Fire alarm			1990	9,537	303	20	477	174	5,962	26
27	Dining room improvements			1992	1,824	58	10	93	35	1,814	27
28	Warehouse storage building			1993	17,802	565	30	593	28	5,930	28
29	100 gal lime tank			1995	3,742	316	15	250	(66)	1,875	29
30	Drywall resident rooms & bathrooms			1996	2,240	57	10	225	168	1,459	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Parking lot	1997	$ 5,000	$ 333	10	$ 500	$ 167	$ 2,750	37
38	Flooring	1997	674	17	10	68	51	342	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	534	39
40	Tile floor	1997	784	20	10	78	58	429	40
41	Water softener	1997	667	17	10	67	50	368	41
42	Interior design	1997	1,245	32	15	83	51	457	42
43									43
44	Flooring	1998	1,130	29	10	113	84	508	44
45									45
46	Roofing	1999	17,240	442	20	862	420	3,340	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	3,559	48
49									49
50	New laundry building	2001	179,249	3,639	20	8,962	5,323	13,904	50
51	Laundry building flooring	2001	1,219	121	10	121		183	51
52	Roof replacement	2001	84,500	451	20	4,225	3,774	6,338	52
53									53
54	Design & remodel dining room	2002	97,732	1,149	40	1,222	73	1,222	54
55	Flooring	2002	39,834	15,933	10	1,991	(13,942)	1,991	55
56	Blinds	2002	2,473	989	10	124	(865)	124	56
57	Awning	2002	996	399	10	50	(349)	50	57
58	Walk in cooler repair	2002	3,361	168	10	168		168	58
59	Lighting	2002	2,563	128	10	128		128	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,478,148	$ 79,889		$ 84,825	$ 4,936	$ 1,211,568	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 431,668	$ 12,545	$ 58,151	$ 45,606	5-10	$ 426,069	71
72	Current Year Purchases	35,035	28,414	2,503	(25,911)	7	2,503	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	$ 657,292	$ 40,959	$ 60,654	$ 19,695		$ 619,161	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1989 Chevrolet van	1989	$ 18,500	$	$	$	4	$ 18,500	76
77	Resident care	1983 Ford pickup	1987	4,700				4	4,700	77
78	Resident care	1999 Dodge Dakota	2000	14,504	2,747	3,626	879	4	7,252	78
79										79
80	TOTALS			$ 37,704	$ 2,747	$ 3,626	$ 879		$ 30,452	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,273,144	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,595	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,105	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,510	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,861,181	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1991 Mercedes Benz (1993)	$ 43,500	$	$ 43,500	86
87	1996 Jeep (1995)	30,199		30,199	87
88	1999 Suburban (2000)	29,810	4,520	23,029	88
89	2001 Envoy (2002)	40,686	7,660	7,660	89
90					90
91	TOTALS	$ 144,195	$ 12,180	$ 104,388	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		N/A		$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 16,089 Description: Mattresses - 12,855; Nursing equipment - 300; Dishwasher - 2,676; Misc. small tool rental - 258
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	5,645	$ 84,680	$	5,645	$ 84,680	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,846	27,693		1,846	27,693	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,707	115,599		7,707	115,599	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				116,802		116,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1, 2, 3)	9,198 hrs	152,412	686	10,294	456	9,884	163,162	12
13	Other (specify): See Sch 16A	See Sch 16A			115	1,524		115	1,524	13
14	TOTAL			$ 152,412	15,999	$ 239,790	$ 117,258	25,197	$ 509,460	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center
Provider #: 0017996
01/01/2002 to 12/31/2002

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
VA Rehab	10A(3)	90	900	
VA Physician	39(3)	25	624	
Total		115	1,524	0

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 211,422	$ 211,422	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,031)	840,940	840,940	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,699	16,699	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	9,826	9,826	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,078,887	$ 1,078,887	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	2,605,134	2,478,148	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	694,996	694,996	16
17	Accumulated Depreciation (book methods)	(1,989,747)	(1,861,181)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan cost	1,494	1,494	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,411,877	$ 1,413,457	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,490,764	$ 2,492,344	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 123,528	$ 123,528	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,097	10,097	29
30	Accrued Salaries Payable	65,996	65,996	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,232	35,232	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,100	17,100	32
33	Accrued Interest Payable	1,614	1,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Non-tax Payroll W/H	2,398	2,398	36
37	Deferred Income-Patient Liability	105,243	105,243	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 361,208	$ 361,208	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	38,426	38,426	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 38,426	$ 38,426	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 399,634	$ 399,634	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,091,130	$ 2,092,710	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,490,764	$ 2,492,344	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Southgate Health Care Center, Inc.
Facility #: 0017996
01/01/2002 - 12/31/2002 **Schedule 17A**

Page 17 - Line 9 - Other	
Employee receivables	9,394
Refundable taxes	432
Total - Line 9	9,826

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,622,104	1
2	Restatements (describe):		2
3			3
4	**Adjustments subsequent to cost report preparation**	(11,615)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,610,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	901,957	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(421,316)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 480,641	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,091,130	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,819,275	1
2	Discounts and Allowances for all Levels	163,165	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,982,440	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	589	5
6	Therapy	544,949	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 545,538	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	162,981	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,575	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 173,556	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,533	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,533	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on sale of asset	3,900	28
28a	See Schedule 19A	3,144	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,044	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,718,111	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	741,973	31
32	Health Care	1,436,735	32
33	General Administration	1,056,126	33
	B. Capital Expense		
34	Ownership	193,441	34
	C. Ancillary Expense		
35	Special Cost Centers	311,229	35
36	Provider Participation Fee	76,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,816,154	40
41	**Income before Income Taxes (line 30 minus line 40)****	901,957	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 901,957	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Southgate Health Care Center. Inc.
Facility #: 0017996
01/01/2002 - 12/31/2002 **Schedule 19A**

Page 19: Line 28a - Other Revenue	
Vending machine commission	1,199
Employee reimbursement of tuition	1,695
(Employee did not complete course)	
Miscellaneous revenue	250
Total - Line 9	3,144

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,948	2,068	$ 37,870	$ 18.31	1
2	Assistant Director of Nursing	2,387	2,515	44,074	17.52	2
3	Registered Nurses	3,293	3,597	59,589	16.57	3
4	Licensed Practical Nurses	24,583	25,247	285,206	11.30	4
5	Nurse Aides & Orderlies	81,053	83,159	561,808	6.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,899	4,342	33,659	7.75	8
9	Activity Director	1,960	2,080	21,372	10.28	9
10	Activity Assistants	5,460	5,892	46,408	7.88	10
11	Social Service Workers	4,105	4,385	45,508	10.38	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	24,340	11.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,303	20,162	120,389	5.97	15
16	Dishwashers					16
17	Maintenance Workers	5,443	5,571	71,055	12.75	17
18	Housekeepers	17,734	18,132	107,173	5.91	18
19	Laundry	10,092	10,504	67,106	6.39	19
20	Administrator	1,960	2,080	64,357	30.94	20
21	Assistant Administrator					21
22	Other Administrative	1,960	2,080	335,455	161.28	22
23	Office Manager	1,960	2,080	29,242	14.06	23
24	Clerical	6,999	7,315	75,926	10.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,735	3,968	35,504	8.95	31
32	Other Health Care(specify)	3,612	3,808	37,753	9.91	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,446	211,065	$ 2,103,794 *	$ 9.97	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 7,898	1(3)	35
36	Medical Director	20	3,900	9(3)	36
37	Medical Records Consultant	32	1,595	10(3)	37
38	Nurse Consultant	24	1,561	10(3)	38
39	Pharmacist Consultant	96	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	398	$ 16,154		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Southgate Health Care Center, Inc.
Facility #: 0017996
01/01/2002 - 12/31/2002

Schedule 20A

Description	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
Page 20: Line 32 - Other Health Care				
Care Plan Coordinator	1,960	2,080	23,514	11.30
Medicare Coordinator	1,652	1,728	14,239	8.24
Total - Line 32	3,612	3,808	37,753	9.91

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle L Cavitt	Administrator	0.00%	$ 64,357
Sam Thompson	Administrative	4.67%	335,455
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 399,812

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See attached Sch 21A		31,657
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,657

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,898
Unemployment Compensation Insurance	17,032
FICA Taxes	144,140
Employee Health Insurance	40,669
Employee Meals	3,255
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	3,829
Employee Retirement	6,079
Employee Recognition & Morale	24,192
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,094

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,756
Health Care Worker Background Check	
(Indicate # of checks performed 135)	1,574
IL Health Care Association dues	7,408
Miscellaneous dues	1,295
Miscellaneous subscriptions	820
Miscellaneous Licenses & fees	547
IHCA PAC contribution	212
Promotional advertising	6,973
Less: Public Relations Expense	(3,533)
Non-allowable advertising	(4,795)
Yellow page advertising	(2,178)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,079

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached Schedule	11,054
Less: Non-allowable expenses	(4,819)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,235

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center, Inc.

Facility ID#: 0017996 **Schedule 21A**

12/31/2002

Professional Services

Name of Vendor		Services Rendered (Legal, Acctg, etc)		Total (For this svcs)
Altschuler, Melvoin & Glasser LLP		Accounting		9,149
Duane Morris LLP		Legal		12,181
Bryant & Katz		Legal-Collections	√	474
Kemper CPA Group		Accounting		3,505
Williams, Williams & Lentz		Accounting		3,250
Whitlow, Roberts, Houston & Straub		Legal-Collections	√	3,075
Brian Katz		Legal-Collections	√	1,214
G. Neil Co.		Employment Services		64
Earthlink, Inc.		Internet Services		347
GIA Real Estate		Title Search		438
Massac County Clerk		Mortgage Release		36
American Express Tax & Business Services, Inc.		Accounting		183
Less: Collections fees returned		Legal		(2,259)
Total = Line 19, col. 3				31,657
	√	Non-allowable legal fees		(4,763)
		Total = Line 19, col. 8		26,894

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association -7,408**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **19,993** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **None** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **-0-**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **0** **04:20 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-48,131	equal to	-48,131	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	14,738	equal to	14,738	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	17,306	equal to	17,306	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	149,105	equal to	149,105	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	16,089	equal to	16,089	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	152,412	equal to	152,412	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	227,972	equal to	228,872	-900	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	117,258	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	741,973	equal to	741,973	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,436,735	equal to	1,436,735	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,056,126	equal to	1,056,126	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	193,441	equal to	193,441	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	311,229	equal to	311,229	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	76,650	equal to	76,650	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,024,051	equal to	943,051	81,000	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	152,412	-152,412	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	67,780	equal to	67,780	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	45,508	equal to	45,508	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	144,729	equal to	144,729	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	71,055	equal to	71,055	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	107,173	equal to	107,173	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	67,106	equal to	67,106	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	399,812	equal to	399,812	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	105,168	equal to	105,168	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,103,794	equal to	2,103,794	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	7,898	< or = to	7,898	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,900	< or = to	3,900	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,356	< or = to	4,356	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	399,812	equal to	399,812	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	31,657	equal to	31,657	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	310,094	equal to	310,094	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,079	equal to	13,079	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,235	equal to	6,235	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	76,650	equal to	76,650	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	3,255	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,004	equal to	4,413	-409	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	48,523	equal to	48,523	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	17,100	equal to	17,100	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	100,000	equal to	100,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,478,148	equal to	2,478,148	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	694,996	equal to	694,996	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,861,181	equal to	1,861,181	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,091,130	equal to	2,091,130	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	901,957	equal to	901,957	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,490,764	equal to	2,490,764	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	144,729	12,897	7,898	165,524	0	165,524	0	165,524
2. Food P	0	184,863	0	184,863	0	184,863	-1,199	183,664
3. Housek	107,173	19,607	0	126,780	0	126,780	0	126,780
4. Laundry	67,106	9,464	0	76,570	0	76,570	0	76,570
5. Heat ar	0	0	66,277	66,277	0	66,277	0	66,277
6. Mainter	71,055	19,157	31,747	121,959	0	121,959	0	121,959
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	390,063	245,988	105,922	741,973	0	741,973	-1,199	740,774
9. Medical	0	0	3,900	3,900	0	3,900	0	3,900
10. Nursin	943,051	141,399	4,356	1,088,806	0	1,088,806	0	1,088,806
10a. Ther	0	0	228,872	228,872	0	228,872	0	228,872
11. Activit	67,780	1,869	0	69,649	0	69,649	0	69,649
12. Social	45,508	0	0	45,508	0	45,508	0	45,508
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	1,056,339	143,268	237,128	1,436,735	0	1,436,735	0	1,436,735
17. Admin	399,812	0	0	399,812	0	399,812	0	399,812
18. Direct	0	0	8,000	8,000	0	8,000	0	8,000
19. Profes	0	0	31,657	31,657	0	31,657	-4,763	26,894
20. Fees,	0	0	23,585	23,585	0	23,585	-10,506	13,079
21. Clerica	105,168	19,357	49,304	173,829	0	173,829	0	173,829
22. Emplo	0	0	310,094	310,094	0	310,094	0	310,094
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	11,054	11,054	0	11,054	-4,819	6,235
25. Other	0	908	13,221	14,129	0	14,129	0	14,129
26. Insura	0	0	83,966	83,966	0	83,966	0	83,966
27. Other	0	0	0	0	0	0	0	0
28. Total (	504,980	20,265	530,881	1,056,126	0	1,056,126	-20,088	1,036,038
29. Total (	1,951,382	409,521	873,931	3,234,834	0	3,234,834	-21,287	3,213,547
30. Depre	0	0	135,775	135,775	0	135,775	13,330	149,105
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	24,271	24,271	0	24,271	-9,533	14,738
33. Real E	0	0	17,306	17,306	0	17,306	0	17,306
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	16,089	16,089	0	16,089	0	16,089
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	193,441	193,441	0	193,441	3,797	197,238
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	152,412	117,258	10,918	280,588	0	280,588	0	280,588
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	76,650	76,650	0	76,650	0	76,650
43. Other	0	0	30,641	30,641	0	30,641	-30,641	0
44. Total S	152,412	117,258	118,209	387,879	0	387,879	-30,641	357,238
45. Grand	2,103,794	526,779	1,185,581	3,816,154	0	3,816,154	-48,131	3,768,023

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	211,422	211,422
2. Cash - F	0	0
3. Account	840,940	840,940
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	0	0
7. Other Pr	16,699	16,699
8. Account	0	0
9. Other (s	9,826	9,826
10. Total c	1,078,887	1,078,887
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	100,000	100,000
14. Buildin	3,300,130	3,300,130
15. Leaseh	0	0
16. Equipn	0	0
17. Accum	########	########
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	1,494	1,494
24. Total L	1,411,877	1,411,877
25. Total A	2,490,764	2,490,764
CURRENT LIABILITIES		
26. Accour	-123,528	-123,528
27. Officer'	0	0
28. Accour	0	0
29. Short-T	-10,097	-10,097
30. Accrue	-65,996	-65,996
31. Accrue	-35,232	-35,232
32. Accrue	-17,100	-17,100
33. Accrue	-1,614	-1,614
34. Deferre	0	0
35. Federa	0	0
36. Other (	-2,398	-2,398
37. Other (	-105,243	-105,243
38. Total C	-361,208	-361,208
LONG TERM LIABILITES		
39.Long-Te	-38,426	-38,426
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	-38,426	-38,426
46.Total Li	-399,634	-399,634
47.Total Eo	-287,216	-287,216
48.Total Li	-686,850	-686,850

		Balance per Medicaid Trial Balance
1.	Gross F	########
2.	Discour	-163,165
	Subtota	########
4.	Day Ca	0
5.	Other C	-589
6.	Therapy	-544,949
7.	Oxygen	0
	Subtota	-545,538
9.	Paymer	0
10.	Other	0
11.	Nurses	-
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Teleph	0
16.	Rental	0
17.	Sale o	-162,981
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	-10,575
22.	Laund	0
	Subtot	-173,556
24.	Contril	0
25.	Interes	-9,533
	Subtot	-9,533
27.	Other	-3,900
28.	Other	-3,144
	Subtot	-7,044
30.	Total F	########
31.	Gener	741,973
32.	Health	1,436,735
33.	Gener	1,056,126
34.	Owner	193,441
35.	Specia	311,229
35.	Provid	76,650
37.	Other	0
40.	Total E	3,816,154
41.	Incom	########
42.	Incom	0
43.	Net In	########

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Line 16 for mortgage insurance.